Health and Social Care in the community

Health and Social Care in the Community (2017) doi: 10.1111/hsc.12426

Sexual health service providers' perceptions of transgender youth in England

Ayla R. F. Lefkowitz MSc[1] and **Jenevieve Mannell** PhD[2]

[1]Department of Social Psychology, London School of Economics and Political Science, London, UK and [2]Institute for Global Health, University College London, London, UK

Accepted for publication 14 December 2016

Correspondence
Ayla R. F. Lefkowitz
London School of Economics and Political Science, Department of Social Psychology, Queens House 55/56 Lincoln's Inn Fields, London WC2A 3LJ, UK
E-mail: lefkowitz.ayla@gmail.com

What is known about this topic

- Most service providers' knowledge of gender and sexual minorities is perceived as inadequate by transgender individuals.
- When accessing health services, transgender people often experience stigma and discrimination.
- Healthcare providers are often uncomfortable during encounters with transgender patients.

What this paper adds

- This paper provides a unique perspective by focusing on sexual health and transgender youth, illuminating issues around gender identity, sexual health and age that have not yet emerged in other studies of its kind.
- In this study, service providers' perceptions were potentially stigmatising and many conflicted with transgender youths' representations of themselves.
- Some service providers did not believe youth could be certain they are transgender and/or make decisions about altering their body.

Abstract

Transgender youth often face difficulties when accessing sexual health services. However, few studies investigate health service providers' perceptions of transgender youth, and fewer focus on sexual health. To fill this gap, our study draws on social representations theory to examine sexual health service providers' perceptions of transgender youth and how this influences the provision of health services for this marginalised population in England. A thematic analysis of 20 semi-structured interviews with service providers, conducted between March and June 2014, resulted in five main themes centred on: binary representations of transgender; transgender as homosexuality; uncertain bodies; unstable mental states; and too young to know. Of the service providers interviewed, many understood transgender within a male/female binary, and perceived being transgender to be synonymous with being gay. There was confusion among service providers regarding transgender youths' sexual organs, and most of those interviewed saw transgender youth as mentally unstable and confused. Finally, many service providers perceived that transgender youth are too young to know that they are transgender and make decisions about their body. Some of these representations were potentially stigmatising and many conflicted with transgender youths' representations of themselves. Training by transgender people is recommended to help address these misunderstandings.

Keywords: service provision, sexual health, transgender, young people

Introduction

Health service providers often lack knowledge about transgender health and display negative attitudes towards transgender patients (Eliason & Hughes 2004, Hoffman *et al.* 2009, Gardner & Safer 2013, Rounds *et al.* 2013). However, little is known about the perceptions of sexual health service providers (referred to as 'service providers') with regard to transgender people, and no studies have investigated service providers' perceptions of transgender youth in particular. Examining service providers' perceptions of transgender youth is crucial, as research shows that professionals' perceptions of marginalised groups affect their treatment of these individuals (Renedo & Jovchelovitch 2007). Furthermore, past studies focusing on transgender health indicate that healthcare providers' understandings and behaviour are regarded by transgender people as essential to a positive experience in health services (Gardner & Safer 2013, Rounds *et al.* 2013) and can affect transgender youth's access to services (Corliss *et al.* 2007).

© 2017 John Wiley & Sons Ltd

The provision of appropriate sexual health services for youth and especially transgender youth is critically important. First, adjusting to changes in one's physical body can be difficult for any adolescent; however, this can be compounded for transgender youth whose sex assigned at birth may be incongruent with their gender identity (Grossman & D'Augelli 2007). Second, while some transgender youth have happy and supportive childhoods, many experience high rates of bullying in school, abuse in childhood and rejection from family members, which can have negative implications for health outcomes and health service utilisation (Grossman & D'Augelli 2006, Holman & Goldberg 2006, Corliss *et al.* 2007, Stieglitz 2009). These social challenges affect their health and well-being, in some cases forcing them into sex work to survive (Holman & Goldberg 2006). Furthermore, scholars working in adolescent health have highlighted youth's particular challenges having their voices heard by health service providers and how healthcare providers perceive age and maturity as factors affecting youth's decision-making abilities (Runeson *et al.* 2002, Beresford & Sloper 2003, Curtis *et al.* 2004, Coyne 2008).

The current study fills an important gap in this literature by using qualitative methods to investigate service providers' perceptions of transgender youth and the implications for health practice. Important factors explored include transgender youths' sexual health, sexual orientation, mental health and age related to decision-making capacity. The term transgender is used in this paper to describe a person who does not identify with the sex and gender they were assigned at birth (Burrows 2011, Winter *et al.* 2016).

Transgender people's access to health services

Transgender people report several difficulties in their interactions with healthcare providers (Kenagy 2005, Sperber *et al.* 2005, Garofalo *et al.* 2006, Corliss *et al.* 2007, Poteat *et al.* 2013, Rounds *et al.* 2013). Transgender people view providers' knowledge on transgender health issues as essential to a positive experience in health services; however, most healthcare providers' knowledge of gender and sexual minorities is perceived as inadequate by transgender individuals (Hoffman *et al.* 2009, Gardner & Safer 2013, Rounds *et al.* 2013). An absence of knowledge about and recognition of transgender youth's particular needs can prevent them from accessing health services (Corliss *et al.* 2007).

When accessing health services, transgender people often experience stigma and discrimination (Kenagy 2005, Sperber *et al.* 2005, Poteat *et al.* 2013). Studies show that healthcare providers are often uncomfortable during encounters with transgender patients (Lurie 2005, Safer & Pearce 2013). A study of human immunodeficiency virus (HIV) treatment in the United States found that providers felt uncomfortable asking transgender patients questions, as they felt ignorant about transgender issues and afraid of using the 'wrong' language (Lurie 2005). Furthermore, Eliason and Hughes (2004) found that many treatment counsellors had negative attitudes towards transgender individuals. Researchers have highlighted the need for more research on the provision of healthcare services for transgender people, with particular attention to the attitudes and perceptions of healthcare providers (Lurie 2005, Dorsen 2012, Snelgrove *et al.* 2012, Poteat *et al.* 2013).

Social representations theory

Social representations theory (SRT) provides a useful theoretical framework for investigating perceptions embedded in our everyday knowledge about the social world, and is therefore drawn on in this study of service providers' perceptions of transgender youth. SRT, first developed by Moscovici (1984), posits that we do not see the world in its objective reality, rather we create subjective categories that represent objects, people and ideas. This means that different groups of people in different social environments can hold distinct social representations of what it means to be transgender. Representations are constructed through social interaction and communication with others (Moscovici 1984, Jovchelovitch 2007). Service providers may therefore have different representations of what it means to be transgender than transgender individuals themselves simply because they are in different social environments with different accepted practices and discourses.

Our social representations of objects or people influence the way we react to or treat them (Moscovici 1984, Renedo & Jovchelovitch 2007). Service providers' social representations of transgender youth therefore affect how they provide sexual health services. This being said, social representations are not static; they change with time through communication with other individuals, groups and institutions, which provides the potential for negative representations to be transformed (Campbell *et al.* 2010).

SRT offers a means of understanding how individuals become familiar with new information about the social world through the concept of 'anchoring'. Anchoring refers to the process of fitting something unfamiliar into one's preconceived framework of social categories. Through this process, a new group

© 2017 John Wiley & Sons Ltd

– such as transgender youth – is fit within the categories one already has available in understanding the social world. However, some attributes of existing categories are also transferred to the new group in order to make it familiar and comprehensible, meaning that the group – transgender youth – does not necessarily take on unique and particular characteristics. Rather, characteristics are transferred from the existing social categories the person holds.

Social representations theory has been used to examine the representations of marginalised groups to gain a better understanding of what contributes to their struggles in society (see Renedo & Jovchelovitch 2007, and Campbell *et al.* 2010). In their study on representations of homelessness held by professionals working with homeless people, Renedo and Jovchelovitch (2007) conclude, 'constructions about homelessness have a direct impact on the construction of practices towards the homeless, the definition of provision and the design of policies, and the identity of the homeless person' (pp. 23). Our study similarly investigates the social representations of transgender youth held by service providers to gain an understanding of their possible effects on health practice and the treatment of transgender youth.

The current study

The research questions guiding the current study included: (i) what are service providers' perceptions of transgender youth? (ii) what are the implications of these perceptions for health practice? The aim of this study was to identify the representations that could impact the treatment of transgender youth and consequently affect their health and well-being. Furthermore, this study worked to develop feasible strategies to improve transgender youths' quality of care in sexual health services. This research provides unique insights into factors that influence service providers' practice with transgender youth and illuminates issues around sexual health and age that have not yet emerged in other studies of its kind.[1]

Methods

Procedure

Purposive sampling was used to include participants with relevant experience delivering sexual health services to transgender youth. Over 2 months, a sexual health organisation for youth with 86 clinics across the United Kingdom sent three participant call-outs via email to their service providers. Participants were given approximately 1 month to respond to the call-outs, and service providers who responded were interviewed. Participant call-outs indicated that the interview would involve a discussion on a marginalised population; however, participants were not told that the interview specifically focused on transgender youth. This was done to prevent participants from preparing in advance, and allowed for preconceived representations of transgender youth to surface.

Semi-structured interviews were conducted as an effective way to discover individuals' opinions on a topic (Rapley 2004, Flick 2014). Semi-structured interviews have been used in other social representations studies for their ability to reveal patterns in how professional groups perceive particular social categories (e.g. Renedo & Jovchelovitch 2007). Interviews in London, Milton Keynes and Birmingham were conducted in-person in participants' workplace, while interviews with participants from Manchester, Salford, Bristol, Cornwall and Blackburn were conducted by Skype or telephone. The duration of interviews ranged from 26 minutes to 1 hour, most of which were approximately 45 minutes, and took place between March and June 2014.

In order to ensure credibility of the data collected (Schwandt *et al.* 2007), the interview topic guide was collaboratively developed by two researchers and reviewed by members of the queer and transgender community. In contrast to previous qualitative research on healthcare providers' levels of knowledge or comfort, the interview questions in this study were constructed to reveal service providers' social representations. The interview topic guide covered four main discussion points relating to participants' perceptions and experiences: (i) Perceptions of transgender identity; (ii) Scenarios with transgender youth; (iii) Perceptions of transgender youth's quality of care in their clinic; (iv) Previous training on health needs of lesbian, gay, bisexual, transgender, queer and intersex youth. Questions included: 'How would you explain 'transgender'?' and 'A transgender girl comes into the clinic for a sexually transmitted infection (STI) test, in your professional experience, how would you proceed?' These questions align with the aim of our study by exposing service providers' perceptions of transgender youth and potential issues related to health practice that could impact the treatment and health of transgender youth.

Research ethics approval was received from the Department of Social Psychology at the London School of Economics. Prior to each interview, the interviewer provided an explanation of the research purpose, the interview process and answered questions. The interviewer asked for permission to audio-record the interview. Following this discussion, participants gave written consent, either in-person or via email.

© 2017 John Wiley & Sons Ltd

Participants

Ten of 86 clinics run by the sexual health organisation for youth were included in this study, as these were the clinics with service providers that responded to the call-out. The sample (N = 20) comprised of sexual health nurses (N = 7), client support workers (N = 6), sexual health counsellors (N = 4) and sexual health advisors (N = 3). Participants worked in different locations in England: London (N = 9), Milton Keynes (N = 5), Birmingham (N = 1), Manchester (N = 1), Salford (N = 1), Bristol (N = 1), Cornwall (N = 1) and Blackburn (N = 1). This sample was sufficient for data saturation to occur.

Data analysis

Each interview was transcribed, organised electronically on Text Analysis Markup System (TAMS) Analyser software and analysed using thematic network analysis (Attride-Stirling 2001). One researcher conducted the first round of analysis, developing initial codes and networks, and a second researcher reviewed the data, edited the codes and aided in developing thematic networks. In order to develop these networks, seven of the interviews were first coded inductively, in which passages in the text that related to the research questions were picked out, grouped and named to form the codes. From these codes, the most salient themes were identified. After this first round of analysis, all 20 interviews were coded in the same way; existing themes were refined and new themes emerged. In the full data set, themes that came up in multiple interviews were labelled as basic themes and then categorised into organising themes connected by a common idea, and finally global themes, which summarised the central claims (Attride-Stirling 2001).

Findings

Five global themes emerged from the data: (1) binary representations of transgender, (2) transgender as homosexuality, (3) uncertain bodies, (4) unstable mental states and (5) too young to know. These global themes describe service providers' perceptions of transgender youth. We will discuss the five global themes in detail, including the organising and basic themes within them.

Global Theme 1: Binary representations of transgender

Participants discussed transgender identity within a gender binary – where only two possible categories of gender experience (man or woman) exist (Table 1).

Table 1 Binary representations of transgender

Global themes	Organising themes	Basic themes
Binary representations of transgender	Binary	Transgender = male to female or female to male
		Transgender = to dress in opposite gender's clothing
		Using binary language
	Beyond the binary	Include identities outside binary
		Don't use binary language

Participants defined transgender as an individual who is either medically transitioning between male and female, or dressing as the other sex. For example, one participant defined transgender as, 'somebody who is transitioning or has transitioned from male to female, female to male' [participant 7]. Furthermore, the binary language used by some participants to describe transgender, such as to 'swap gender' [participant 11] or change to the 'opposite sex' [participant 5], suggested that they perceived transgender to be within a system of only two genders/sexes.

Only two participants explicitly stated that transgender identity could include identities outside the gender binary, such as youth who identify as genderqueer. As one participant described:

> I would explain that [transgender] would include everybody who identified as transsexual, transgender, transvestite, anyone with a trans history ... Whether they describe themselves as a binary man or non-binary, whether they are genderqueer or whatever. [Participant 1]

Our findings therefore point to two different representations of transgender arising from the data: transgender within a gender binary and beyond the binary. While both representations exist in our data, the former was by far the most prevalent.

Global Theme 2: Transgender as homosexuality

Several participants linked the sexual orientation and gender identity of transgender youth, assuming that transgender youth were also gay (Table 2). When asked about the first thing that comes to mind when thinking of transgender youth, one participant replied, 'I think transgender is when you're questioning your sexuality and you're not sure what's what' [participant 8]. Similarly, in a discussion on what questions to ask transgender clients versus other clients before an STI test, one participant explained:

> I ask [clients] if they have been in any relationships recently and ask them what those were like ... And that would be

© 2017 John Wiley & Sons Ltd

Table 2 Transgender as homosexuality

Global themes	Organising themes	Basic themes
Transgender as homosexuality	Transgender youth tend to be gay	Confuse transgender identity with sexual orientation
		Being transgender affects sexual orientation
	Transgender identity not tied to sexuality	Transgender identity not the same as being gay
		Do not assume transgender youths' sexual orientation
	Transgender youth are actually gay and not transgender	Youth who think they are transgender might really be gay
		Perceive transgender to mean gay

exactly the same with someone who identifies as transgender, except that their sexual partner is going to be different. [Participant 3]

This participant assumed transgender clients would have a gay sexual partner. Only three participants acknowledged any distinction between gender identity and sexual orientation.

Two participants perceived that transgender youth may be mistaken about being transgender, and may actually be gay. This can be seen through the following:

A young boy who's thinking, I want to be a female or I can become a female, they might be attracted to males, basically ... if it's a male thinking that they're female and therefore they're thinking that because they're attracted to males. [Participant 11]

In this excerpt, the participant infers that transgender youth cannot be certain about being transgender and can confuse their attraction to people of the same sex with feelings of wanting to change their gender identity.

Participants' perceptions of transgender youths' sexual orientation can impact their health practice, where someone is swabbed for an STI test is contingent on whether one takes part in vaginal, oral and/or anal sex. Therefore, if a service provider perceives that transgender youth are not heterosexual, they may make assumptions about the kind of sex the youth are partaking in.

Global Theme 3: Uncertain bodies

Among participants, there were conflicting perceptions of transgender youths' bodies and sexual organs (Table 3). While some participants perceived that transgender youth had not had sex reassignment surgery, others perceived they had undergone surgery, while some perceived that either scenario could be possible. One participant remarked: 'Typically someone who is transgender is someone who is pre-operative' [participant 3]. In contrast, another participant commented: 'I'm thinking transgender sort of had operations' [participant 20].

Table 3 Uncertain bodies

Global themes	Organising themes	Basic themes
Uncertain bodies	Whether transgender youth have had surgery or not	Has had surgery
		Has not had surgery
		Could have either had surgery or not had surgery
	Uncertain about appearance of body during transition	Not clear where in transition youth is
		Uncertain about appearance of youths' body

Participants' uncertainty about transgender youths' bodies seemed to increase when they perceived that a client was going through transition. When discussing which STI test to give a transgender girl, one participant stated:

When it's clearly people who've made the journey, and so everything matches up if you like, that's fine ... But it's when people are crossing over in between, do you know what I mean? You know, do they have a penis or not? [Participant 13]

This quote suggests that the participant felt uncertain when transgender youths' bodies did not fit the expected anatomy of either males or females. Participants perceived transgender youth's bodies during transition as more ambiguous.

Participants' uncertainty about transgender youths' sexual organs also influenced whether they administer a urine sample or a vaginal swab. To test for Chlamydia, the British Association for Sexual Health and HIV guidelines state that vaginal swabs should be used for females and urine tests for males (BASHH, 2010). This is because vaginal swabs result in specimens with higher sensitivities than urine samples (Spigarelli & Biro 2004). However, some participants explained that they would give all transgender youth a urine test, as they would not know whether the person had a vagina. For example, one participant explained:

Unless they come out and say well, you know I can't take a [vaginal] swab test because I've had surgery, then I'd say ok, no worries, well we'll just send your urine off ... the sort of person that is transgender person that's had surgery, if they're comfortable enough to do that, I would assume that they would be comfortable enough to tell me.

© 2017 John Wiley & Sons Ltd

Otherwise, I would just proceed and do the routine urine test, which can be done for male or female. [Participant 20]

In this case, if transgender youth do not reveal what their genitals look like, the service provider would offer a urine sample as a default test. Two participants suggested that they would feel slightly uncomfortable asking transgender youth about their sexual organs. The practice of only giving urine samples to transgender youth can be problematic if the person could take a vaginal swab and was not given the choice. Thus, participants' uncertainty about transgender youths' bodies and poor communication with the youth may result in poor health practice.

Global Theme 4: Unstable mental states

Many participants discussed transgender youth as mentally unstable (Table 4). When asked about the first thing they imagine when thinking about transgender youth, participants used words, such as 'distressed' [participant 10], 'withdrawn' [participant 4], 'unhappy' [participants 8, 9, 10], 'depressed' [participant 3] and in need of support [participants 2, 4, 14, 15, 16, 20]. For example, one participant remarked:

I think the DSM diagnostic manual for psychological therapy etcetera still regards trans ... as a potential mental health issue. I think I would agree with that. I still think that they, you know, it's such a significant change to make, there may well be mental health issues involved. [Participant 15]

Broadly, participants perceived being transgender as negatively affecting mental health.

Table 4 Unstable mental states

Global themes	Organising themes	Basic themes
Unstable mental states	Unstable mental health	Distressed
		Withdrawn
		Unhappy
		Depressed
		Has mental health issues
		In need of support/counselling
		Self-hate
	Confused with self	Confused
		Not confident
	External influences on mental health	Bullied
		Face difficulties
		Misunderstood
		Lack of external support
		Isolated
		Vulnerable
		Scared of what others will think
	Not always in need of support	Doesn't always need support
		Not always unstable
		Strong

Several participants explained this link between being transgender and mental ill-health as resulting from transgender youth's confusion over their identity. For example, when describing transgender youth, one participant explained:

You kind of feel for them in a little way because they must be very confused ... maybe they're feeling that they're not the person, or not the same as they're brought up to be, so it must be very difficult for them. [Participant 16]

Many participants suggested counselling for transgender youth to address this concern.

Participants also perceived that transgender youth face difficulties in society that negatively affect their mental health. Participants used the following words to describe transgender youth: 'isolated' [participant 14], 'vulnerable' [participants 8, 13], 'bullied' [participant 1, 3, 10], 'mistreated' [participant 10] and 'misunderstood' [participant 1]. Without adequate external acceptance of their identity, many participants perceived that transgender youth could develop mental health issues.

The mental health issues that participants perceived transgender youth to experience appeared to stem from two places: discriminatory treatment by others or being transgender/confusion over self-identity. Only three participants acknowledged that not all transgender youth necessarily have these mental health issues. For example, one remarked that the following scenario is possible: 'It may be that she's a transgender person and she's completely comfortable with who she is and she doesn't want any support' [participant 14].

Global Theme 5: Too young to know

Several participants perceived transgender youth to be too young to be certain that they are transgender (Table 5). One participant explained:

You might not know because you're still going through puberty, your hormones are changing so you don't actually know definitely ... people experiment with sexuality when they're going through puberty and he'll still be going through puberty so. [Participant 9]

This quote infers that youths' changing hormones affect their ideas about their gender identity. This perception of the impact of changes during adolescence was present in a few interviews, while other participants felt that the strength of transgender youths' conviction depends on how long they have felt transgender. Of note, one participant explained surprise that youth would be identifying as transgender at all, considering their age. Only two participants in this study recommended that they should simply believe that the youth know they are transgender.

© 2017 John Wiley & Sons Ltd

Table 5 Too young to know

Global themes	Organising themes	Basic themes
Too young to know	Youth cannot be certain they are transgender	Unsure of whether they are actually transgender
		Can still change their mind
		Depend on how long they have felt transgender
	Too young to make important decisions about their body	Cannot consent to body alteration
		Transition should be a slow process
		Fourteen is too young to make these decisions
		Youth are too young to make these decisions
		Need parent involvement
		How long they have felt transgender affects whether they can make these decisions
		Surprised that someone that young would be transgender
	Age does not affect decision-making	Age does not matter
		Depends on the individual
		Support youth in making informed decisions
		Believe them when they say they are transgender

Participants also perceived that transgender youth are too young to make decisions about their body, specifically to undergo hormone therapy or sex reassignment surgery. For example, when asked about a young person's ability to make decisions about their body at about age 14 or 16, one participant replied:

> I believe they may feel that they're already 100% but you know ... I thought I knew everything at 14, do you know what I mean? But a decision like that is a huge decision. Without taking it away from them, I also think it's imperative that they wait to see if they're always going to feel like that ... at that age, there's a lot of experimentation with everything, with your sexuality ... the way you dress and the music you listen to, everything constantly changing, you've got hormones firing in your body anyway, and they're adjusting to their body. Somebody at that age would need somebody to talk to about it, and to continue talking to them about it really until they're at the age I guess, where they can make a decision ... enough time, maybe, to know 100% that they'd always feel like that. [Participant 6]

This quote demonstrates that 'experimentation' is perceived as an element of being young, and therefore, important decisions should not be made during this time. Several participants advocated that transgender youths' transition should be a slow process, and some also remarked that the amount of time the young person has believed they are transgender is an important factor in determining whether the young person is able to make decisions about altering their body.

Many of these participants explained that the ability to make these decisions also depends on the individual, and that they would support youth in making informed decisions. A smaller number of participants perceived that age did not make any difference to decision-making.

Discussion

Summarising the findings from our study of service providers' perceptions of transgender youth, we found that many of the service providers interviewed understood transgender identity within a male-female binary and thought that transgender youth were also gay. Furthermore, many service providers felt uncertain about transgender youths' sexual organs during transition, and most perceived that transgender youth had mental health issues. Lastly, a number of service providers did not believe youth could be certain they are transgender and/or make decisions about altering their body.

When comparing transgender people's perceptions of their own gender identity with service providers' perceptions of transgender identity in this study, there are clear differences between the two representations. Research investigating transgender identity demonstrates that there are a number of transgender individuals that do not see themselves as either male or female, rather they may identify as genderqueer or non-binary (Holman & Goldberg 2006, Monro 2007, Diamond & Butterworth 2008, Davis 2009, Nagoshi *et al.* 2012). In contrast, service providers in this study perceived transgender identity as switching from male to female or vice versa. Furthermore, past research posits that many transgender youth identify as heterosexual, clearly conflicting with service providers' representations of transgender youth as gay (Garofalo *et al.* 2006). For example, in Garofalo *et al.*'s (2006) study on the struggles of ethnic minority male-to-female transgender youth, 26% of the transgender youth identified as heterosexual.

In returning to our theoretical framework for this study, we can gain better understandings of the

© 2017 John Wiley & Sons Ltd

implications of these representations between service providers and those of transgender youth. As a social constructionist framework, SRT does not see any representation as more valuable than another, rather subjects are understood to draw on different representations depending on their social location, situation, role and identity (Howarth *et al.* 2015). This allows us to see service providers' representations of transgender as a product of their own understanding of the world and their specific role as health providers. The process of representing transgender identity within the gender binary can be seen as a form of 'anchoring' for service providers. As previously described, anchoring is the process of fitting a less familiar idea into one's preconceived framework of social representations. The common social representation of gender is that people are either male or female (Butler 1990, Nieder & Richter-Appelt 2011, Joel *et al.* 2013), while transgender is less familiar. By perceiving transgender youth as simply transitioning to the 'opposite sex' service providers are fitting transgender identity into their familiar binary representation of gender.

On the other hand, the anchoring process of service providers can also be stigmatising for transgender youth who feel that their identity is misrepresented or unseen. Youth who feel that their identities are not being acknowledged may be less likely to seek help from sexual health services or follow the advice of service providers. The tendency of service providers to associate transgender experiences with mental distress also has potentially stigmatising affects. However, this depends on the perceived cause of the distress. Winter *et al.* (2009) pointed out that seeing transgender identity as a mental health concern in itself rather than perceiving that mental health issues result from external influences can further stigmatise transgender people. For this reason, many have argued that including transgender identity in the Diagnostic and Statistical Manual of Mental Disorders could be harmful to transgender individuals (Lev 2006, Green *et al.* 2011). In a study of marginalised youth, Howarth (2002) argued that negative social representations can become internalised as part of one's social identity, thus contributing to low self-esteem and self-hatred. Similar processes of internalising negative representations as part of one's social identity have been observed among gay men living with HIV (Joffe 1995) and smokers from low socioeconomic groups (Farrimond & Joffe 2006). The association of mental ill-health with transgender experiences can therefore create the very issues service providers are trying to address if youth feel that their identities are somehow being understood as problematic. However, acknowledging the psychological burden of external experiences faced by transgender youth (including social exclusion, discrimination and targeted violence) is an important and much needed role for service providers to play.

The focus of this study on transgender youth in particular has raised other important issues pertaining to conflicts in the representations held by service providers and their clients. The conviction shared by many service providers in this study that transgender youth were too young to know whether they were indeed transgender or to make decisions about their bodies stands in direct conflict with the desire of youth to formulate their own identity. Our findings are not uncommon among the wider literature on children and youth's involvement in health-related decision-making. An observational study of youth's involvement in decision-making during hospitalisation showed that medical staff members often explain courses of action without consulting the young patients or providing alternatives (Runeson *et al.* 2002). Furthermore, children often report feeling ignored or disbelieved (Beresford & Sloper 2003, Curtis *et al.* 2004, Coyne 2008). Beresford and Sloper (2003) found that during consultations with healthcare providers, youth, especially younger adolescents, often perceived being excluded from conversations about their health. In order to effectively address negative consequences of sexual behaviours, including STIs, practitioners and policy makers must recognise the accounts and perspectives of young people on sexual matters (Aggleton & Campbell 2000). Moreover, protective and didactic approaches to the experiences of transgender youth may only serve to undermine their agency in protecting themselves against STIs by contributing to a lack of confidence in their decision-making ability. Alternative approaches can be found in recent scholarship on the importance of recognising marginalised individuals' agency and allowing them to establish their own definition of what actions mean for their lives (Mannell *et al.* 2016).

Limitations

The participants' responses to the interview questions may have been affected by the principle researcher's role as a volunteer for the organisation. It is plausible that participants altered their answers to appear more knowledgeable or accepting of transgender youth than they actually were in order to sound professional or competent in front of a volunteer at the organisation. Second, although precautions were taken to avoid a scenario in which participants prepared for the interviews beforehand, it is possible that some participants heard about the specific topic

© 2017 John Wiley & Sons Ltd

of the interview from past participants. Third, participants may have responded differently based on the interview method (in-person interviews versus Skype and telephone). Fourth, although members of the transgender community reviewed the measuring instrument, the instrument was not piloted. Lastly, as all the participants worked at the same sexual health organisation, they may have received similar mandatory trainings, which may have affected our findings. In order to address this potential limitation, we made an effort to include participants working at different clinics in different cities across England, in order to allow for greater chance of diversity in training and experience.

Implications for health practice and conclusions

Like the majority of studies investigating health service providers' perspectives of transgender people (e.g. Poteat *et al.* 2013, Winter *et al.* 2016), we also recommend further training on transgender health for service providers. However, unlike other research, the findings of this study suggest that more specific guidance for the execution and content of this training is needed. Given the need to recognise transgender youth identities as defined by the youth themselves, training programs for service providers would benefit greatly from the involvement of transgender youth. This would help acknowledge that there is no one clear representation of what it means to be transgender, and that the largest gains to be made in challenging stigma and discrimination within health service provision is through encouraging open discussions about transgender experiences, sexualities and bodies. Furthermore, as many service providers in this study had misunderstandings about transgender identity, it is recommended that health clinics partner with and distribute resources from local organisations that specialise in supporting transgender youth. This will allow transgender youth to access specialised support where their experiences are more fully understood. Reisner *et al.* (2016) make similar recommendations when discussing the importance of gender-affirming services for optimum transgender healthcare. Considering the lack of research on transgender youth and their sexual health, further research should continue to investigate this topic to ensure transgender youth receive quality healthcare.

Acknowledgements

We thank the sexual health service providers who gave their time to participate in this study.

Disclosure statement

The authors do not have any financial interest or benefit resulting from this research.

Note

[1]As researchers implicated in the study we carry out, it is essential to point out that we are not transgender. That being said, we are dedicated to challenging discrimination against transgender people. We work to be allies by respecting the self-determination of transgender individuals, striving to generate more inclusive health services and critically evaluating research practices that pathologise transgender people.

References

Aggleton P. & Campbell C. (2000) Working with young people – towards an agenda for sexual health. *Sexual and Relationship Therapy* **15** (3), 283–296.

Attride-Stirling J. (2001) Thematic networks: an analytic tool for qualitative research. *Qualitative Research* **1** (3), 385–405.

BASHH (2010) *Chlamydia trachomatis UK Testing Guidelines*. British Association for Sexual Health and HIV. Available at: http://www.bashh.org/documents/3352.pdf (accessed on 15/7/2014).

Beresford B.A. & Sloper P. (2003) Chronically ill adolescents' experiences of communicating with doctors: a qualitative study. *Journal of Adolescent Health* **33** (3), 172–179.

Burrows G. (2011) Lesbian, gay, bisexual and transgender health, part 2: gender identity. *Practice Nurse* **41** (4), 5–22.

Butler J. (1990) *Gender Trouble: Feminism and the Subversion of Identity*, 1st edn. Routledge, New York, NY, USA.

Campbell C., Skovdal M., Mupambireyi Z. & Gregson S. (2010) Exploring children's stigmatisation of AIDS-affected children in Zimbabwe through drawings and stories. *Social Science & Medicine* **71** (5), 975–985.

Corliss H.L., Belzer M., Forbes C. & Wilson E.C. (2007) An evaluation of service utilization among male to female transgender youth: qualitative study of a clinic-based sample. *Journal of LGBT Health Research* **3**, 49–61.

Coyne I. (2008) Children's participation in consultation and decision-making at health service level: a review of the literature. *International Journal of Nursing Studies* **45** (2008), 1682–1689.

Curtis K., Liabo K., Roberts H. & Barker M. (2004) Consulted but not heard: a qualitative study of young people's views of their local health service. *Health Expectations* **7**, 149–156.

Davis E. (2009) Situating "fluidity"(trans) gender identification and the regulation of gender diversity. *GLQ: A Journal of Lesbian and Gay Studies* **15** (1), 97–130.

Diamond L. & Butterworth M. (2008) Questioning gender and sexual identity: dynamic links over time. *Sex Roles* **59** (5–6), 365–376.

Dorsen C. (2012) An integrative review of nurse attitudes towards lesbian, gay, bisexual, and transgender patients. *Canadian Journal of Nursing Research* **44** (3), 18–43.

Eliason M.J. & Hughes T. (2004) Treatment counselor's attitudes about lesbian, gay, bisexual and transgender clients:

© 2017 John Wiley & Sons Ltd

urban vs. rural settings. *Substance Use & Misuse* **39** (4), 624–644.

Farrimond H.R. & Joffe H. (2006) Pollution, peril and poverty: a British study of the stigmatization of smokers. *Journal of Community & Applied Social Psychology* **16** (6), 481–491.

Flick U. (2014) Mapping the field. Chapter 1. In: U. Flick (Ed.) *The SAGE Handbook of Qualitative Analysis*, 3–8. SAGE Publications Ltd, London, UK.

Gardner I. & Safer J. (2013) Progress on the road to better medical care for transgender patients. *Current Opinion in Endocrinology, Diabetes and Obesity* **20** (6), 553–558.

Garofalo R., Deleon J., Osmer E., Doll M. & Harper G. (2006) Overlooked, misunderstood and at-risk: exploring the lives and HIV risk of ethnic minority male-to-female transgender youth. *Journal of Adolescent Health* **38** (3), 230–236.

Green J., McGowan S., Levi J., Wallbank R. & Whittle S. (2011) Recommendations from the WPATH consensus process for revision of the DSM diagnosis of gender identity disorders: implications for human rights. *International Journal of Transgenderism* **13** (1), 1–4.

Grossman A.H. & D'Augelli A.R. (2006) Transgender youth: invisible and vulnerable. *Journal of Homosexuality* **51**, 111–128.

Grossman A.H. & D'Augelli A.R. (2007) Transgender youth and life threatening behaviors. *Suicide and Life-Threatening Behavior* **37**, 527–537.

Hoffman N., Freeman K. & Swann S. (2009) Healthcare preferences of lesbian, gay, bisexual, transgender and questioning youth. *Journal of Adolescent Health* **45** (3), 222–229.

Holman C. & Goldberg J. (2006) Ethical, legal, and psychosocial issues in care of transgender adolescents. *International Journal of Transgenderism* **9** (3–4), 95–110.

Howarth C. (2002) Identity in whose eyes? The role of representations in identity construction. *Journal for the Theory of Social Behaviour* **32** (2), 145–162.

Howarth C., Cornish F. & Gillespie A. (2015) Making community: diversity, movement and interdependence. In: E. Sammut, E. Andreouli, G. Gaskell & J. Valsiner (Eds) *The Cambridge Handbook of Social Representations*, pp. 179–190. Cambridge University Press, Cambridge, UK.

Joel D., Tarrasch R., Bermana Z., Mukameld M. & Zive E. (2013) Queering gender: studying gender identity in 'normative' individuals. *Psychology & Sexuality* **5** (4), 291–231.

Joffe H. (1995) Social representations of AIDS: towards encompassing issues of power. *Papers on Social Representations* **4** (1), 29–40.

Jovchelovitch S. (2007) *Knowledge in Context*, 1st edn. Routledge, London, UK.

Kenagy G.P. (2005) Transgender health: findings from 2 needs assessment studies in Philadelphia. *Health and Social Work* **30** (10), 19–26.

Lev A. (2006) Disordering gender identity: gender identity disorder in the DSM-IV-TR. *Journal of Psychology & Human Sexuality* **17** (3–4), 35–69.

Lurie S. (2005) Identifying training needs of health-care providers related to treatment and care of transgendered patients: a qualitative needs assessment conducted in New England. *The International Journal of Transgenderism* **8** (2–3).

Mannell J., Jackson S. & Umutoni A. (2016) Women's responses to intimate partner violence in Rwanda: rethinking agency in constrained social contexts. *Global Public Health* **11** (1–2), 65–81.

Monro S. (2007) Transmuting gender binaries: the theoretical challenge. *Sociological Research Online* **12** (1). Retrieved from: http://www.socresonline.org.uk/12/1/monro.html.

Moscovici S. (1984) The phenomenon of social representations. In: R. Farr & S. Moscovici (Eds) *Social Representations*, pp. 3–69. University Press, Cambridge, UK.

Nagoshi J.L., Brzuzy S. & Terrell H.K. (2012) Deconstructing the complex perceptions of gender roles, gender identity, and sexual orientation among transgender individuals. *Feminism & Psychology* **22** (4), 405–422.

Nieder T. & Richter-Appelt H. (2011) Tertium non datur–either/or reactions to transsexualism amongst health care professionals: the situation past and present, and its relevance to the future. *Psychology & Sexuality* **2** (3), 224–243.

Poteat T., German D. & Kerrigan D. (2013) Managing uncertainty: a grounded theory of stigma in transgender health care encounters. *Social Science & Medicine* **84**, 22–29.

Rapley T. (2004) Interviews. Chapter 1. In: C. Seale, G. Gobo, J.F. Gubrium & D. Silverman (Eds) *Qualitative Research Practice*, pp. 15–33. Sage, London, UK.

Reisner S.L., Poteat T., Keatley J. *et al.* (2016) Global health burdens and needs of transgender populations: a review. *The Lancet* **388**, (10042), 412–436.

Renedo A. & Jovchelovitch S. (2007) Expert knowledge, cognitive polyphasia and health: a study on social representations of homelessness among professionals working in the voluntary sector in London. *Journal of Health Psychology* **12** (5), 779–790.

Rounds K.E., Mcgrath B.B. & Walsh E. (2013) Perspectives on provider behaviors: a qualitative study of sexual and gender minorities regarding quality of care. *Contemporary Nurse: A Journal for the Australian Nursing Profession* **44** (1), 99–110.

Runeson I., Hallstrom I., Elander G. & Hermeren G. (2002) Children's participation in the decision-making process during hospitalisation: an observational study. *Nursing Ethics* **9** (6), 583–598.

Safer J. & Pearce E. (2013) A simple curriculum content change increased medical student comfort with transgender medicine. *Endocrine Practice* **19** (4), 633–637.

Schwandt T.A., Lincoln Y.S. & Guba E.G. (2007) Judging interpretations: but is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. *New Directions for Evaluation* **2007** (114), 11–25.

Snelgrove J., Jasudavisius A., Rowe B., Head E. & Bauer G. (2012) "Completely out-at-sea" with "two-gender medicine": a qualitative analysis of physician-side barriers to providing healthcare for transgender patients. *BMC Health Services Research* **12** (1), 1–13.

Sperber J., Landers S. & Lawrence S. (2005) Access to health care for transgendered persons: results of a needs assessment in Boston. *International Journal of Transgenderism* **8**, 75–91.

Spigarelli M. & Biro F. (2004) Sexually transmitted disease testing: evaluation of diagnostic tests and methods. *Adolescent Medicine Clinics* **15** (2), 287–299.

Stieglitz K.A. (2009) Development, risk, and resilience of transgender youth. *Journal of the Association of Nurses in AIDS Care* **21**, 192–206.

Winter S., Chalungsooth P., Teh Y. *et al.* (2009) Transpeople, transprejudice and pathologization: a seven-country factor analytic study. *International Journal of Sexual Health* **21** (2), 96–118.

Winter S., Diamond M., Green J., Karasic D., Reed T., Whittle S. & Wylie K. (2016) Transgender people: health at the margins of society. *The Lancet* **388** (10042), 390–400.

 © 2017 John Wiley & Sons Ltd